



310 COVERED SERVICES

● AUDIOLOGY

Description. Audiology is an AHCCCS covered service, within certain limitations, to evaluate hearing loss and rehabilitate persons with hearing loss through other than medical/surgical means.

Amount, Duration and Scope. AHCCCS covers medically necessary audiology services to evaluate hearing loss for all members, on both an inpatient and outpatient basis. Hearing aids can be dispensed only by a dispensing audiologist or an individual with a valid hearing aid dispensing license. Hearing aids, provided as a part of audiology services, are covered only for members receiving EPSDT services and KidsCare members up to age 21.

Beginning June 28, 2004, audiology services must be provided by an audiologist who is licensed by the Arizona Department of Health Services (ADHS) and who meets the Federal requirements specified under Title 42 of the Code of Federal Regulations (42 CFR) 440.110. Out-of-state audiologists must meet the Federal requirements.

The Federal requirements mandate that the audiologist must have a Master's or Doctoral degree in audiology and meet one of the following conditions:

1. Have a certificate of clinical competence in audiology granted by the American Speech-Language-Hearing Association (ASHA), or
2. Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or be in the process of accumulating such supervised clinical experience under the supervision of a qualified Master's or Doctoral-level audiologist), performed not less than nine months of supervised full-time audiology services after obtaining a Master's or Doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary of the U.S. Department of Health and Human Services.

Refer to [Chapter 1200](#) for additional information on services provided to ALTCS members.



● **BEHAVIORAL HEALTH SERVICES**

Description. AHCCCS covers behavioral health services (mental health and/or substance abuse services) within certain limits for all members except those enrolled to receive family planning extension services only. The following outlines the service delivery system for behavioral health services.

Acute Care Program

1. Title XIX and Title XXI Members are eligible to receive medically necessary behavioral health services. Services are provided through the Arizona Department of Health Services and its contracts with Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs). Native American members may receive behavioral health services from an IHS/638 facility, a TRBHA, or be referred to a RBHA. Services are listed in the amount, duration and scope section of this policy and described with limitations in [Appendix G](#), the Behavioral Health Services Guide. Managed care primary care providers, within the scope of their practice, who wish to provide psychotropic medications and medication adjustment and monitoring services may do so for members diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder, mild depressive and/or anxiety disorders.

Contractors are responsible for providing inpatient emergency behavioral health services for up to 72 hours after admission to managed care members with psychiatric or substance abuse diagnoses who are enrolled with a Contractor and are not behavioral health recipients (not to exceed 12 days per contract year).

2. Family Planning Extension Program Members enrolled in the SOBRA Family Planning Extension Program are not eligible for behavioral health services.

Arizona Long Term Care System (ALTCS) Program

ALTCS members are eligible to receive medically necessary behavioral health services through ALTCS Contractors, Tribal Contractors, Department of Economic Security/Division of Developmental Disabilities, and AHCCCS registered fee-for-service (FFS) providers. Refer to [Appendix G](#) and [Chapters 1200](#) and [1600](#) of this Manual for additional information regarding ALTCS behavioral health services.



Amount, Duration and Scope.

Covered behavioral health services for acute and ALTCS members include, but are not limited to:

1. Inpatient hospital services
2. Inpatient psychiatric facility services including subacute facilities and residential treatment centers for persons under age 21
3. Institution for mental disease with limitations (See Appendix G)
4. Behavioral health counseling and therapy, including electroconvulsive therapy
5. Psychotropic medication
6. Psychotropic medication adjustment and monitoring
7. Respite care
8. Partial care (supervised day program, therapeutic day program and medical day program)
9. Behavior management (behavioral health personal care, behavioral health home care training, behavioral health self-help/peer support)
10. Psychosocial rehabilitation (skills training and development, behavioral health promotion/education, psychoeducational services, ongoing support to maintain employment, and cognitive rehabilitation)
11. Screening, evaluation and assessment
12. Case management services
13. Laboratory, radiology, and medical imaging services for diagnosis and psychotropic medication regulation



14. Emergency and non-emergency medically necessary transportation
15. Behavioral health therapeutic home care services, and/or
16. Emergency behavioral health services for managed care and FFS members who are not in the FESP (refer to Chapter 1100 for all requirements regarding FESP).
 - a. Emergency behavioral health services are described under A.A.C. R9-22-210.01. An emergency behavioral health condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - 1) Placing the health, including mental health, of the member in serious jeopardy (this includes serious harm to self)
 - 2) Serious impairment to bodily functions
 - 3) Serious dysfunction of any bodily organ or part, or
 - 4) Serious physical harm to another person.

Acute symptoms include severe psychiatric symptoms.

- b. An emergency behavioral health evaluation is covered as an emergency behavioral health service if:
 - 1) Required to evaluate or stabilize an acute episode of mental disorder or substance abuse, and
 - 2) Provided by a qualified provider who is:
 - a) A behavioral health medical practitioner as defined in 9 A.A.C. 22, Article 1, including a licensed psychologist, a licensed clinical social worker, a licensed professional counselor, a licensed marriage and family therapist, or
 - b) An ADHS/DBHS-contracted provider.



A provider is not required to obtain prior authorization for emergency services. Regarding emergency services, refer to Exhibit 310-1 for a reprint of A.A.C. R9-22-210.01 that describes general provisions for responsible entities, payment and denial of payment, notification requirements and post-stabilization requirements.

Refer to A.A.C. R9-22-217 and [Chapter 1100](#) of this Manual for information regarding behavioral health services for members eligible for services through the Federal Emergency Services Program.

Refer to [Chapter 1200](#) for more information regarding behavioral health services for members eligible for the ALTCS program.

Refer to [Appendix G](#) for further information on AHCCCS covered behavioral health services and settings.

- **BREAST RECONSTRUCTION AFTER MASTECTOMY**

Description. AHCCCS covers breast reconstruction surgery for eligible members following a medically necessary mastectomy regardless of AHCCCS eligibility at time of mastectomy.

Amount, Duration and Scope. Breast reconstruction surgery is a covered service if the individual is AHCCCS eligible, and as noted in this section. The member may elect to have breast reconstruction surgery immediately following the mastectomy or may choose to delay breast reconstruction, but the member must be AHCCCS eligible at the time of breast reconstruction surgery. The type of breast reconstruction performed is determined by the physician in consultation with the member.



Coverage policies for breast reconstructive surgery include:

1. Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered an effective non-cosmetic procedure. Breast reconstruction surgery following removal of a breast for any medical reason is a covered service.
2. Medically necessary implant removal is a covered service. Replacement of implants is a covered service when the original implant was the result of a medically necessary mastectomy. Replacement of implants is not a covered service when the purpose of the original implant was cosmetic (e.g., augmentation).
3. External prostheses, including a surgical brassiere, will be covered for members who choose not to have breast reconstruction, or who choose to delay breast reconstruction until a later time. Refer to the durable medical equipment (DME) policy in this Chapter for information regarding covered DME services.

Limitations:

1. AHCCCS does not cover services provided solely for cosmetic purposes (R9-22-205). If a member has had an implant procedure for cosmetic purposes (e.g., augmentation) not related to a mastectomy, medically necessary removal is covered but replacement is not.
2. Reconstructive breast surgery of the unaffected contralateral breast following mastectomy will be considered medically necessary only if required to achieve relative symmetry with the reconstructed affected breast. Except in extraordinary circumstances, the medical necessity of reconstructive breast surgery must be determined by the surgeon, in consultation with the Contractor's Medical Director, at the time of reconstruction or during the immediate post-operative period.

Prior authorization (PA) from the AHCCCS Division of Fee for Service Management is required for breast reconstruction surgery provided to FFS members. Refer to [Chapter 800](#) for further discussion of PA requirements for FFS providers.



● **DENTAL SERVICES FOR MEMBERS 21 YEARS OF AGE AND OLDER**

Description. AHCCCS covers the following dental services, provided by a licensed dentist, for members who are 21 years of age and older:

1. Emergency dental services
2. Medically necessary dentures, and
3. Pre-transplant dental services.

Dental services for members younger than age 21, including preventive and therapeutic dental services, are discussed in [Chapter 400](#) of this Manual.

Amount, Duration and Scope.

AHCCCS requires Contractors to provide at least the following:

1. Coordination of covered dental services for enrolled AHCCCS members
2. Documentation of current valid contracts with dentists who practice within the Contractor service area(s)
3. Primary care provider to initiate member referrals to dentist(s) when the member is determined to be in need of dental emergency services, or members may self-refer to a dentist when in need of emergency dental services.
4. Monitoring of the provision of dental services and reporting of encounter data to AHCCCS, and



5. Assurance that copies of Contractor, and AHCCCS, emergency dental policies and procedures have been provided to contracted dentist(s).

Emergency Dental Care - Medically necessary emergency dental care and extractions are covered for all members who meet the criteria for an emergency as defined in this Chapter for managed care members, [Chapter 800](#) for FFS members, and [Chapter 1100](#) for FESP members. The following services and procedures are covered only under emergency circumstances:

1. Emergency oral diagnostic examination (limited oral examination – problem focused)
2. Radiographs and laboratory services, limited to the symptomatic teeth
3. Composite resin involving incisal angle due to recent tooth fracture
4. Prefabricated crowns, to eliminate pain due to recent tooth fracture only
5. Recementation of clinically sound inlays, crowns and fixed bridges
6. Pulp cap, direct plus protective filling
7. Vital pulpotomies performed on six (6) maxillary teeth and six (6) mandibular anterior teeth only
8. Apicoectomy performed as a separate procedure on anterior teeth, for treatment of acute infection or to eliminate pain, with favorable prognosis
9. Immediate and palliative procedures, including extractions if medically necessary, for relief of severe pain associated with an oral or maxillofacial condition
10. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis
11. Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment)
12. Initial treatment for acute infection, including, but not limited to, perapical and periodontal infections and abscesses by appropriate methods



13. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone or soft tissue, and
14. Preoperative procedures and anesthesia appropriate for optimal patient management.

Prior authorization from the AHCCCS Division of Fee for Service Management is not required for emergency dental procedures provided to FFS members.

Medically Necessary Dentures - AHCCCS covers partial or complete dentures, and related services when determined to be medically necessary by the primary care provider (PCP) in conjunction with the member's attending dentist, to alleviate the member's health problem. The PCP and attending dentist must provide documentation which clearly shows that dentures are medically necessary for the ongoing and continued health of the member. Neither the inability to properly masticate nor cosmetic considerations, alone or in combination, constitute medical necessity for dentures.

The following circumstances should be considered when determining coverage of dentures or for the replacement of dentures for members who are edentulous or partially edentulous:

1. The member's existing dentures are no longer serviceable and cannot be relined or rebased
2. The member's health would be adversely affected by the absence of prosthesis
3. The member has been able to wear dentures successfully in the past and has not gone more than six months without wearing a prosthetic replacement
4. If partial dentures are recommended, they must be deemed essential for function. As a standard, it may be considered that six posterior teeth in occlusion (three maxillary and three mandibular teeth in functional contact with each other) will be considered adequate for functional purposes. Abutment teeth must be free of decay and periodontally sound.
5. Denture repair will be approved only if it is essential to the serviceability of the appliance.



Limitations to the Coverage of Dentures

1. Radiographs are limited to use as a diagnostic tool preceding treatment of symptomatic teeth and to support the need for, and provision of, dentures
2. Provision of dentures for cosmetic purposes is not a covered service
3. Extraction of asymptomatic teeth is not a covered service, unless their removal is medically necessary and constitutes the most cost-effective dental procedure for the provision of medically necessary dentures.

Limitations to the Coverage of Emergency Dental Services

1. Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible
2. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma
3. Routine restorative procedures and routine root canal therapy are not emergency services
4. Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection
5. Root canals are limited to six (6) maxillary anterior teeth and six (6) mandibular teeth, and only when indicated as treatment for acute infection or to eliminate pain.

Dental Services for Members Eligible for Transplantation Services - AHCCCS covers dental diagnosis and elimination of oral infection prior to transplantation of organs or tissues only after the member has been established as an otherwise appropriate candidate for transplantation. Refer to the transplantation section of this policy for additional information regarding specific transplantation services.



● **DIALYSIS**

Description. AHCCCS covers hemodialysis and peritoneal dialysis services provided by participating hospitals and End Stage Renal Disease facilities. All services, supplies, diagnostic testing (including routine medically necessary laboratory tests) and drugs medically necessary for the dialysis treatment are covered.

Amount, Duration and Scope. Medically necessary outpatient dialysis treatments are covered. Inpatient dialysis treatments are covered when the hospitalization is for:

1. Acute medical condition requiring dialysis treatments (hospitalization related to dialysis)
2. AHCCCS covered medical condition requiring inpatient hospitalization experienced by a member routinely maintained on an outpatient chronic dialysis program, or
3. Placement, replacement or repair of the chronic dialysis route.

NOTE: Hospital admissions solely to provide chronic dialysis are not covered.

NOTE: Hemoperfusion is covered when medically necessary.

Refer to [Chapter 1100, Policy 1120](#), for policy related to dialysis coverage within the Federal Emergency Services Program (FESP).



● **EMERGENCY MEDICAL SERVICES**

Description. As specified in A.A.C. R9-22-210, AHCCCS covers emergency medical services for managed care and FFS members who are not in the Federal Emergency Services Program (FESP). Refer to Chapter 1100 for all requirements regarding FESP.

Emergency medical services are provided for the treatment of an emergency medical condition. An emergency medical condition is a medical condition, including labor and delivery, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the member's health in serious jeopardy
2. Serious impairment of bodily functions, or
3. Serious dysfunction of any bodily organ or part.

Amount, Duration and Scope. Emergency medical services are covered for members when there is a demonstrated need, and/or after triage/emergency medical assessment services indicate an emergency condition.

A provider is not required to obtain prior authorization for emergency services. Regarding emergency services, refer to Exhibit 310-1 for a reprint of A.A.C. R9-22-210 that describes general provisions for responsible entities, payment and denial of payment, notification requirements and post-stabilization requirements.

Utilization of emergency services. Managed care Contractors must educate their members regarding the appropriate utilization of emergency room services. Members should be encouraged to obtain services from non-emergency facilities (e.g., urgent care centers) to address member non-emergency care after regular office hours or on weekends.



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Refer to [Chapter 500](#) for the policy regarding member transfers after an emergency hospitalization.

Refer to [Chapter 800](#) for additional information regarding emergency medical services for FFS members who are not in FESP.

Refer to [Chapter 1100](#) for a complete discussion of covered emergency medical services under the FESP.

Refer to A.A.C. R9-22-217 and [Chapter 1100](#) of this Manual for a complete discussion of covered emergency medical services under the FESP.



● **EYE EXAMINATIONS/OPTOMETRY SERVICES**

Description. AHCCCS covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Amount, Duration and Scope. Emergency eye care which meets the definition of an emergency medical condition is covered for all members. For members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered. Vision examinations and the provision of prescriptive lenses are covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program, KidsCare Program and for adults when medically necessary following cataract removal. Refer to [Chapter 400](#) for detailed information regarding coverage of eye exams and prescriptive lenses for children.

Cataract removal is covered for all eligible members. Cataract removal is a covered service when the cataract is visible by exam, ophthalmoscopic or slit lamp, and any of the following apply:

1. Visual acuity that cannot be corrected by lenses to better than 20/70 and is reasonably attributable to cataract
2. In the presence of complete inability to see posterior chamber, vision is confirmed by potential acuity meter reading, or
3. For FFS members, who have corrected visual acuity between 20/50 and 20/70, a second opinion by an ophthalmologist to demonstrate medical necessity may be required. Refer to the Contractors regarding requirements for their enrolled members.

Cataract surgery is covered only when there is a reasonable expectation by the operating ophthalmic surgeon that the member will achieve improved visual functional ability when visual rehabilitation is complete.



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Cataract surgeries are generally done on an outpatient basis, but an inpatient stay may be required due to the need for complex medical and nursing care, multiple ocular conditions or procedures, or the member's medical status. Admission to the hospital may be deemed safer due to age, environmental conditions or other factors.

Other cases that may require medically necessary ophthalmic services include, but are not limited to:

1. Phacogenic Glaucoma, and
2. Phacogenic Uveitis.

Refer to [Chapter 800](#) for prior authorization requirements for FFS providers.



● **HEALTH RISK ASSESSMENT AND SCREENING TESTS**

Description. AHCCCS covers health risk assessment and screening tests provided by a physician, primary care provider or other licensed practitioner within the scope of his/her practice under State law for all members. These services include appropriate clinical health risk assessments and screening tests, immunizations, and health education, as appropriate for age, history and current health status.

Health risk assessment and screening tests are also covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program and KidsCare Program. Refer to [Chapter 400](#) for complete details.

Amount, Duration and Scope. Preventive health risk assessment and screening test services for non-hospitalized adults include, but are not limited to:

1. Hypertension screening (annually)
2. Cholesterol screening (once, additional tests based on history)
3. Routine mammography annually after age 50 and at any age if considered medically necessary
4. Cervical cytology (annually for sexually active women, after three successive normal exams the test may be less frequent)
5. Colon cancer screening (digital rectal exam and stool blood test, annually after age 50)
6. Sexually transmitted disease screenings (at least once during pregnancy, other based on history)
7. Tuberculosis screening (once, with additional testing based on history, or, for AHCCCS members residing in a facility, as necessary per health care institution licensing requirement)
8. HIV screening



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9. Immunizations (refer to separate section within this policy)
10. Prostate screening (annually after age 50, screening is recommended annually for males 40 and older who are at high risk due to immediate family history), and
11. Physical examinations, periodic health examinations or assessments, diagnostic work ups or health protection packages designed to: determine risk of disease, provide early detection of disease, detect the presence of injury or disease, establish a treatment plan, evaluate the results or progress of treatment plan or the disease, or to establish the presence and characteristics of a physical disability which may be the result of disease or injury.

Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.

Physical examinations not related to covered health care services or performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

1. Qualification for insurance
2. Pre-employment physical examination
3. Qualifications for sports or physical exercise activities
4. Pilots examinations (Federal Aviation Administration)
5. Disability certification for the purpose of establishing any kind of periodic payments, or
6. Evaluation for establishing third party liability.

The AHCCCS Division of Fee-for-Service Management does not require prior authorization for medically necessary health risk assessment and screening services performed by fee-for-service providers.



- **HOME HEALTH SERVICES**

Description. AHCCCS covers medically necessary home health services provided in the member's place of residence as a cost effective alternative to hospitalization. Covered services, within certain limits, include: home health nursing visits, home health aide services, medically necessary supplies and therapy services in accordance with Arizona Revised Statutes 36-2907 for AHCCCS members.

ALTCS covers home health services for members who are either elderly and/or have physical disabilities (E/PD) and/or members with developmental disabilities receiving home and community based services. Refer to [Chapter 1200](#) for additional information.

Amount, Duration and Scope. Home health nursing and home health aide services are provided on an intermittent basis as prescribed by a primary care provider or treating physician in accordance with 9 A.A.C. 10, Article 11, Home Health Agencies. Physical therapy services provided by a licensed home health agency (HHA) are covered for acute care, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), KidsCare and ALTCS members. Speech and occupational therapy services provided by a licensed HHA are covered for EPSDT and ALTCS members only.

Refer to [Chapter 800](#) for prior authorization requirements for FFS providers.



● **HOSPICE SERVICES**

Description. AHCCCS covers hospice services allowable under 42 CFR 418.202 for terminally ill members who meet the specified medical criteria/requirements. Hospice services provide palliative and support care for terminally ill members and their family members or caregivers in order to ease the physical, emotional, spiritual and social stresses which are experienced during the final stages of illness and during dying and bereavement.

These services are provided in the member's own home; for ALTCS members, an ALTCS home and community based (HCB) approved alternative residential setting as specified in Policy 1230 of this Manual; or the following inpatient settings when the conditions of participation are met as specified in 42 CFR 418:

1. Hospital,
2. Nursing care institution, and
3. Free standing hospice.

Providers of hospice care must be Medicare certified and licensed by the Arizona Department of Health Services (ADHS), and have a signed AHCCCS provider agreement.

Note: For dual eligible members, Medicare is the primary payor of hospice services.

Definitions. For purposes of this policy the following definitions apply:

1. Continuous home care means hospice care provided during periods of crisis for a minimum of eight hours per 24-hour day (the hours do not have to be continuous). To qualify as home care under this section, the care must be predominantly nursing care, provided by a registered nurse or a licensed practical nurse. Homemaker and home health aide services may also be provided to supplement the care. Continuous home care is only furnished during brief periods of crisis and only as necessary to allow terminally ill hospice-eligible members to maintain residence in their own home or for ALTCS members, a HCB approved ALTCS alternative residential setting. Continuous home care is not available to members residing in a NF Medicaid certified bed.



2. Inpatient respite care means services provided in an inpatient setting, such as a NF, on a short term basis to relieve family members or other caregivers who provide care to hospice eligible members who have elected to receive hospice care and who reside in their own home, or, for ALTCS members, an ALTCS HCB alternative residential setting.
3. General inpatient care means services provided in an inpatient setting, such as a hospital, to hospice-eligible members who have elected to receive hospice care. These services are provided for such purposes as pain control or acute or chronic symptom management, which cannot be managed in another setting.
4. Period of crisis means a period in which the hospice-eligible member requires continuous care to achieve palliation or management of acute medical symptoms.
5. Routine home care means short term, intermittent hospice care including skilled nursing, home health aide and/or homemaker services provided to a hospice-eligible member in his or her own home, or, for an ALTCS member, an ALTCS HCB approved alternative residential setting. Routine home care services may be provided on a regularly scheduled and/or on-call basis. The hospice-eligible member must not be receiving continuous home care services as defined in this section at the time routine home care is provided. Routine home care is available to members residing in a NF Medicaid certified bed.

Amount, Duration and Scope. In order to receive hospice services the member requires a physician's certification stating that the member's prognosis is terminal, with the member's life expectancy not exceeding six months. Due to the uncertainty of predicting courses of illness, the hospice benefit is available beyond six months provided additional physician certifications are completed.



The physician certification is only permitted for two 90-day periods. However, an unlimited number of physician certifications for 60 day periods are permitted thereafter. State licensure standards for hospice care require providers to include skilled nursing, respite and bereavement services. Hospice providers must also have social services, counseling, dietary services, homemaker, personal care and home health aide services and inpatient services available as necessary to meet the member's needs. The following components are included in hospice service reimbursement when provided in approved settings:

1. Bereavement services provided by the hospice which include social and emotional support offered to the member's family both before and up to twelve months following the death of that member. There is no additional cost to AHCCCS for bereavement services provided to the family after the death of the member.
2. Continuous home care (as specified in the definition of hospice in this policy) which may be provided only during a period of crisis.
3. Dietary services which include a nutritional evaluation and dietary counseling when necessary.
4. Home health aide services.
5. Homemaker services.
6. Nursing services provided by or under the supervision of a registered nurse.
7. Pastoral/counseling services provided by an individual who is qualified through the completion of a degree in ministry, psychology or a related field and who is appropriately licensed or certified.
8. Hospice respite care services which are provided on an occasional basis, not to exceed more than five consecutive days at a time. Respite care may not be provided when the member is a nursing facility resident or is receiving services in an inpatient setting indicated above.
9. Routine home care, as specified in the definition of hospice services.
10. Social services provided by a qualified social worker.



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11. Therapies which include physical, occupational, respiratory, speech, music and recreational therapy.
12. Twenty-four hour on-call availability to provide services such as reassurance, information and referral for members and their family members or caretakers.
13. Volunteer services provided by individuals who are specially trained in hospice care and who are supervised by a designated hospice employee. Under 42 CFR 418.70, if providing direct patient care, the volunteer must meet qualifications required to provide such service(s).
14. Medical supplies, appliances and equipment, including pharmaceuticals, which are used in relationship to the palliation or management of the member's terminal illness. Appliances may include durable medical equipment such as wheelchairs, hospital beds or oxygen equipment.

Refer to Chapter 1200, Policy 1250, of this Manual for further explanation regarding hospice and ALTCS members.



● **HOSPITAL INPATIENT SERVICES**

Description. AHCCCS covers medically necessary inpatient hospital services provided by a licensed participating hospital for all eligible members, as specified in 9 A.A.C. 22, Article 2.

Amount, Duration and Scope. Inpatient hospital services for members include, but are not limited to, the following:

Hospital accommodation, and appropriate staffing, supplies, equipment and services for:

1. Routine acute medical care
2. Intensive care and coronary care
3. Neonatal intensive care
4. Maternity care including labor, delivery and recovery rooms, birthing centers, and nursery and related services
5. Nursery for newborns and infants
6. Surgery including surgical suites and recovery rooms, and anesthesiology services
7. Acute behavioral health emergency services
8. Nursing services necessary and appropriate for the member's medical condition
9. Dietary services, and/or
10. Medical supplies, appliances and equipment consistent with the level of accommodation.



Ancillary Services

1. Chemotherapy
2. Dental surgery for members in the Early and Periodic Screening, Diagnosis and Treatment Program
3. Dialysis
4. Laboratory services
5. Pharmaceutical services and prescribed drugs
6. Podiatry services performed by a podiatrist and ordered by a primary care provider
7. Radiological and medical imaging services
8. Rehabilitation services including physical, occupational and speech therapies
9. Respiratory therapy
10. Services and supplies necessary to store, process and administer blood and blood derivatives, and/or
11. Total parenteral nutrition.

AHCCCS covers semiprivate inpatient hospital accommodations, except when the member's medical condition requires isolation.

Refer to [Chapter 800](#) for prior authorization requirements for FFS providers.



● **HYSTERECTOMY**

Description. AHCCCS covers medically necessary hysterectomy services.

Amount, Duration and Scope. AHCCCS does not cover a hysterectomy procedure if it is performed solely to render the individual permanently incapable of reproducing.

Coverage of hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis, and, except for treatment of carcinoma and/or management of life-threatening hemorrhage, has been preceded by a trial of therapy (medical or surgical), which was proven unsatisfactory.

Hysterectomy services may be considered medically necessary without trial of therapy in the following cases:

1. Invasive carcinoma of the cervix
2. Ovarian carcinoma
3. Endometrial carcinoma
4. Carcinoma of the fallopian tube
5. Malignant gestational trophoblastic disease
6. Life-threatening uterine hemorrhage, uncontrolled by conservative therapy; or
7. Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruptio.



In other cases, medical necessity for a hysterectomy is established by failure of more conservative medical and surgical therapy. For example:

1. Dysfunctional Uterine Bleeding or Benign Fibroids associated with Dysfunctional Bleeding: A hysterectomy should be confined to members for whom medical and surgical therapy has failed and childbearing is no longer a consideration.
2. Endometriosis: A hysterectomy is indicated in members with severe disease when future child-bearing is not a consideration, or when disease is refractory to medical or surgical therapy
3. Uterine Prolapse: A hysterectomy can be indicated for the symptomatic parous member for whom childbearing is no longer a consideration and for whom non-operative and/or surgical correction, i.e., suspension, repair will not provide the member adequate relief.

The provider performing hysterectomy procedures must ensure the member is aware that the procedure will result in sterility. The member must signify by dated signature that she has been informed and understands the consequences of having a hysterectomy. This documentation must be kept in the member's medical record. A copy must also be kept in the member's medical record maintained by the primary care provider if enrolled with a Contractor.

The provider is not required to complete a Consent to Sterilization form prior to performing hysterectomy procedures and the 30 day waiting period required for sterilization does not apply to hysterectomy procedures.

Contractors may elect to use the sample hysterectomy consent form for fee-for-service (FFS) providers found in Chapter 800 (Exhibit 820-1) or they may elect to use other formats.

Refer to [Chapter 800](#) for prior authorization requirements for FFS providers.



● IMMUNIZATIONS

Description. AHCCCS covers immunizations as appropriate for age, history and health risk, for adults and children.

AHCCCS follows recommendations as established by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). Covered immunizations for adults include, but are not limited to:

1. Diphtheria-tetanus
2. Influenza
3. Pneumococcus
4. Rubella
5. Measles
6. Hepatitis-B
7. Pertussis, as currently recommended by the CDC or ACIP
8. Zoster vaccine, for members 60 and older
9. HPV vaccine, for females through age 26

Covered immunizations for children are identified in [Chapter 400](#).

Amount, Duration and Scope. Immunizations for passport or visa clearance are not covered by AHCCCS.

The AHCCCS Division of Fee-for-Service Management does not require prior authorization for medically necessary immunization services performed by FFS providers.



● **LABORATORY**

Description. AHCCCS covers medically necessary laboratory services prescribed by a primary care provider, other practitioner or dentist which are ordinarily provided in Clinical Laboratory Improvement Act (CLIA) approved hospital, independent clinic, physician's office and other health care facility laboratories for all eligible members as defined in 9 A.A.C. 22, Article 2.

Amount, Duration and Scope. Medically necessary diagnostic testing and screening are covered services.

Refer to the AHCCCS FFS Provider Manual for information regarding CLIA requirements for AHCCCS covered laboratory services. This manual is available on the AHCCCS Web site (www.azahcccs.gov).

The AHCCCS Division of FFS Management does not require prior authorization for medically necessary laboratory services performed by FFS providers.



- **MATERNAL AND CHILD HEALTH SERVICES**

Description. AHCCCS covers a comprehensive set of services for pregnant women, newborns and children, including maternity care, family planning services and services provided through the Early and Periodic Screening, Diagnosis and Treatment Program.

Refer to [Chapter 400](#) for a complete discussion of covered maternal and child health services.



● **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES**

Description. AHCCCS covers reasonable and medically necessary medical supplies, durable medical equipment (DME) and orthotic/prosthetic devices when prescribed by a primary care provider, a practitioner or by a dentist within certain limits based on member age and eligibility, as specified in 9 A.A.C. 22, Article 2. For the purposes of this policy, medical supplies are consumable items that are designed specifically to meet a medical purpose. DME means sturdy, long lasting items and appliances that can withstand repeated use, are designed to serve a medical purpose and are not generally useful to a person in the absence of a medical condition, illness or injury. Covered prosthetic and orthotic devices are designed to replace or augment a missing or impaired part of the body and are only covered when they are essential for the habilitation or rehabilitation of a member.

DME and devices are used to assist members in optimizing their independence and maintaining placement in the most integrated setting. This may include an institutional setting as appropriate. An example for the institutional setting is the authorization of customized medical devices such as wheelchairs. Criteria for the authorization of a customized wheelchair must be the same regardless of setting as each setting is considered the member's home.

Personal care items are not covered unless needed to treat a medical condition except for limited conditions as described herein. The AHCCCS program covers incontinence briefs for members over age 3 and under age 21 as described in Chapter 400, Policy 430. Except for incontinence briefs as described in Policy 430, personal care items are not covered solely for preventive purposes. Personal care items include items of personal cleanliness, hygiene and grooming.

Amount, Duration and Scope. Covered medical supplies, durable medical equipment and orthotic/prosthetic devices include, but are not limited to:

1. Medical supplies - surgical dressings, splints, casts and other consumable items, which are not reusable, and are designed specifically to meet a medical purpose
2. Durable equipment - wheelchairs, walkers, hospital beds, bedpans and other durable items that are rented or purchased, and



3. Orthotic/prosthetic devices which are essential to the rehabilitation of the member. Osseointegrated implants, devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer, are considered prosthetic devices. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformation, chronic disease, severe sensorineural hearing loss or surgery.

The Contractor must make timely determinations of coverage. The Contractor shall not refuse to render a timely determination based on the member's dual eligibility status or the providers' contract status with the Contractor. If a dual eligible member resides in a nursing facility, the prior authorization request must not be denied on the basis that Medicare is responsible for coverage of DME.

The following criteria must be used in determining coverage:

1. Medical necessity in setting up and/or maintaining the member in the most appropriate setting while maximizing the member's independence and functional level both physically and mentally, and
2. The most reasonable and cost effective alternative to provide medically necessary services in the most appropriate setting and maximizing the member's independence.

Medical equipment may be purchased or rented only when there are no reasonable alternative resources from which the medically necessary medical equipment can be obtained at no cost. Additionally, the total expense of rental cannot exceed the purchase price of the item.

Rental fees must terminate no later than the end of the month in which the member no longer needs the medical equipment, or when the member is no longer eligible or enrolled with a Contractor, except during transitions as specified by the AHCCCS Chief Medical Officer or designee.

Reasonable repairs or adjustment of purchased medical equipment is covered when necessary to make the equipment serviceable and when the cost of the repair is less than the cost of rental or purchase of another unit.



AHCCCS **does not** cover the following:

1. Personal care items, unless needed to treat a medical condition. Exception: AHCCCS covers incontinence briefs for person over 3 and under 21 as described in Policy 430.
2. First aid supplies (except under a prescription)
3. Hearing aids for members who are 21 years of age and older
4. Prescriptive lenses for members who are 21 years of age and older (except if medically necessary following cataract removal), and/or
5. Penile implants or vacuum devices for AHCCCS members who are 21 years of age or older.

Refer to [Chapter 800](#) for prior authorization requirements for FFS providers.

Refer to [Chapter 1200](#) for further information related to ALTCS.



● **NON-PHYSICIAN SURGICAL FIRST ASSISTANT SERVICES**

Description. AHCCCS will cover services provided by non-physician surgical first assistants who are licensed in Arizona as a physician's assistant or registered nurse, and who are registered as an AHCCCS provider to render non-physician surgical first assistant services. The provider must furnish documentation of compliance with the following requirements:

1. Each non-physician surgical first assistant provider must have the sponsorship of an Arizona-licensed physician, and receive supervision from the physician as required under their scope of practice.
2. Non-physician surgical first assistant services must be provided under the supervision of a physician surgeon licensed to practice in Arizona and registered with AHCCCS as a provider.
3. Providers of non-physician surgical first assistant services must hold liability insurance which meets or exceeds limits required for AHCCCS registration.
4. Providers must be currently certified in advanced cardiac life support and CPR, and
5. Non-physician surgical first assistants must be:
 - a. Currently licensed in Arizona either as a registered nurse with current Registered Nurse First Assistant certification (CRNFA) by the National Certification Board of Perioperative Nursing (AORN approved), or as a nurse practitioner with appropriate surgical first assistant training, or
 - b. Currently licensed in Arizona to practice as a physician's assistant. Physician's assistants must provide services under the supervision of their supervising physician or a supervising physician agent who has been approved by the Arizona Joint Board on the Regulation of Physician Assistants as stipulated within their scope of practice and required by law.



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Amount, Duration and Scope. The non-physician surgical first assistant is governed by professional guidelines as determined by their licensing and/or certifying agency and the medical staffing bylaws of the facility where services are provided. Any non-physician surgical first assistant who has had his/her professional license suspended or revoked is ineligible for registration for this provider type or AHCCCS coverage for services.



● **NURSING FACILITY (NF) SERVICES**

Description. AHCCCS covers medically necessary services provided in nursing facilities for those acute care program members who need nursing care 24 hours a day, but who do not require hospital care under the daily direction of a physician. NF service providers must be State licensed and Medicare certified. Religious nonmedical health care institutions are exempt from licensure or certification requirements.

The Arizona Long Term Care System (ALTCS) offers more extensive coverage of NF services for members. Refer to [Chapter 1200](#) for information regarding ALTCS covered services. In lieu of NF services, the member may be placed in an alternative home and community based setting (HCBS), or may receive home and community based services in their home, as defined in the Arizona Administrative Code R9-22, Article 2 and R9-28, Article 2.

Amount, Duration and Scope. AHCCCS covers up to 90 days of NF services per contract year (generally October 1 through September 30) for members who have not been determined eligible for ALTCS.

- The medical condition of the member must be such that if NF services are not provided, hospitalization of the individual will result or the treatment is such that it cannot be administered safely in a less restrictive setting, i.e., home with home health services.
- The 90 days of coverage is per member, per contract year, and does not begin again if the member transfers to a different NF. Acute care members residing in a NF at the beginning of a new contract year begin a new 90-day coverage period. Unused days do not carry over. See the table below for examples.
- The 90 days of AHCCCS acute care coverage for NF services begins on the day of admission regardless of whether the member is insured by a third party insurance carrier, including Medicare. (Refer to the AHCCCS Contractor Operations Manual, Policies 201 and 202 regarding member cost sharing.)



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If the member has applied for ALTCS and a decision is pending, the acute care Contractor must notify the ALTCS Eligibility Administrator (Mail Drop 2600) when the member has been residing in a NF for 75 days. This will allow for time to follow-up on the status of the ALTCS application. If the member becomes ALTCS eligible and is enrolled with an ALTCS Contractor before the end of the maximum 90 days of NF coverage, the acute care Contractor is only responsible for NF coverage during the time the member is enrolled with the acute care Contractor. The NF must coordinate with the member or representative on alternative methods of payment for continuation of services beyond the 90 days covered by the acute care Contractor until the member is enrolled in the ALTCS program, or until the beginning of the new contract year.

Member A	Admitted January 15	Discharged April 3	79 days. 11 days of NF services remain available through September 30.
Member B	Admitted January 15	Still in NF April 14	90 days. NF should have contacted member's Contractor at least 15 days before to discuss alternatives. Contractor should have contacted AHCCCS by Day 75 regarding ALTCS application.
Member C	Admitted July 3	Still in NF September 30	89 days, but new contract year begins October 1. 90 days begin again.

NOTE: For most, but not all, AHCCCS Contractors, the contract year runs from October 1 through September 30. Providers should contact the member's Contractor for verification of contract dates and any discussion needed regarding the member's stay.

Services that are not covered separately by Acute Care or ALTCS Contractors when provided in a NF include:

1. Nursing services, including:
 - a. Administration of medication
 - b. Tube feedings
 - c. Personal care services
 - d. Routine testing of vital signs and blood glucose monitoring



- e. Assistance with eating, and/or
 - f. Maintenance of catheters.
- 2. Basic patient care equipment and sickroom supplies such as bedpans, urinals, diapers, bathing and grooming supplies, walkers and wound dressings or bandages
 - 3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating
 - 4. Administrative physician visits made solely for the purpose of meeting State certification requirements
 - 5. Non-customized durable equipment and supplies such as: wheelchairs, geriatric chairs, and bedside commodes
 - 6. Rehabilitation therapies prescribed as a maintenance regimen
 - 7. Administration, Medical Director services, plant operations and capital
 - 8. Over-the-counter medications and laxatives
 - 9. Social activity, recreational and spiritual services, or
 - 10. Any other services, supplies or equipment that are State or County regulatory requirements or are included in the NF's room and board charge.

Refer to [Chapter 800](#) for PA requirements for FFS providers.



● **OBSERVATION SERVICES**

Description. Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation to determine whether the member should be admitted for inpatient care, discharged or transferred to another facility. Observation services include: the use of a bed, periodic monitoring by a hospital's nursing or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

It is not observation status when a member with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the member in the hospital for less than 24 hours. (This is an outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized or whether services were rendered after midnight.)

Extended stays after outpatient surgery must be billed as recovery room extensions.

Observation services must be provided in a designated "observation area" of the hospital unless such an area does not exist.

Amount, Duration and Scope. Observation status must be ordered in writing by a physician, or other individual authorized by hospital staff bylaws, to admit patients to the hospital or to order outpatient diagnostic tests or treatments. Observation status should not exceed 24 hours. If the 24 hour time limit is exceeded in order to complete evaluation of the medical condition and/or treatment of a member, AHCCCS notification is required for coverage.

Factors that must be taken into consideration by the physician or authorized individual when ordering observation status:

1. Severity of the signs and symptoms of the member
2. Degree of medical uncertainty that the member may experience an adverse occurrence



3. Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the member to remain at the hospital for 24 hours or more) to assist in assessing whether the member should be admitted
4. The availability of diagnostic procedures at the time and location where the member presents
5. It is reasonable, cost effective and medically necessary to evaluate a medical condition or to determine the need for inpatient admission, and
6. Length of stay for observation status is medically necessary for the member's condition.

The following services are not AHCCCS covered observation services:

1. Substitution of outpatient services provided in observation status for physician ordered inpatient services
2. Services that are not reasonable, cost effective and necessary for diagnosis or treatment of member
3. Services provided solely for the convenience of the member or physician
4. Excessive time and/or amount of services medically required by the condition of the member
5. Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for observation status.

Medical Record Documentation of Observation Status

The following are required for documenting medical records:

1. Orders for observation status must be written on the physician's order sheet, not the emergency room record, and must specify, "admit to observation." Rubber stamped orders are not acceptable



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2. Follow-up orders must be written within the first 24 hours, and at least every 24 hours if observation status is extended.
3. Changes from "observation status to inpatient" or "inpatient to observation status" must be made per physician order.
4. Inpatient to observation status must be made by a physician or authorized individual and occur within 12 hours after admission as an inpatient, and
5. Inpatient/outpatient status change must be supported by medical documentation.

Refer to [Chapter 800](#) for prior authorization and utilization management requirements for FFS providers.



- **PHYSICIAN SERVICES**

Description. AHCCCS covers physician services for all members within certain limits based on member age and eligibility. Physician services include medical assessment, treatment, and surgical services performed in the office, clinic, hospital, home, nursing facility or other location by a licensed doctor of medicine or osteopathy.

Amount, Duration and Scope. Physician services are covered as appropriate to the member's medical need and the physician's scope of practice.

Complete physical examinations for new members to determine risk of disease, provide early detection and to establish a prevention or treatment plan for the member, and annual periodic examinations to monitor health status are covered.

AHCCCS does not cover physician services routinely performed and not directly related to the medical care of a member (e.g., physician visits to an NF for the purpose of 30-60 day certification).

AHCCCS does not cover moderate sedation (i.e., conscious sedation) performed by the physician performing the underlying procedure for which sedation is desired, or by another provider except as described below, for the adult population. Refer to [Chapter 400](#), Policy 430, for criteria related to coverage of conscious sedation for members under the age of 21.

AHCCCS does cover monitored anesthesia care, including all levels of sedation, provided by qualified anesthesia personnel (physician anesthesiologist or certified registered nurse anesthetist) for the adult population and members under the age of 21.

Refer to [Chapter 800](#) for prior authorization requirements for FFS providers.



● **PODIATRY SERVICES**

Description. AHCCCS covers medically necessary podiatry services when ordered by a member's primary care provider, attending physician or practitioner, within certain limits, for eligible members. Services must be provided by a licensed podiatrist in compliance with A.A.C. Title 4, Chapter 25.

Amount, Duration and Scope. Coverage includes medically necessary routine foot care, limited bunionectomy services, casting for the purpose of constructing or accommodating orthotics, medically necessary orthopedic shoes or shoes that are an integral part of a brace. Routine foot care is not covered except as noted in this policy.

For purposes of this policy, routine foot care includes the cutting or removal of corns or calluses; the trimming of nails (including mycotic nails) and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury or symptoms involving the foot. Such routine foot care is generally not deemed medically necessary and therefore is usually not covered by AHCCCS.

When the patient has a systemic disease of sufficient severity that performance of routine foot care procedures by a nonprofessional person would be hazardous, then procedures ordinarily considered routine foot care are covered as medically necessary foot care. Conditions that might necessitate medically necessary foot care include metabolic, neurological and peripheral vascular systemic diseases. Examples include, but are not limited to:

1. Arteriosclerosis obliterans (arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
2. Buerger's disease (thromboangiitis obliterans)
3. Chronic thrombophlebitis
4. Diabetes mellitus
5. Peripheral neuropathies involving the feet
6. Member receiving chemotherapy



7. Pernicious Anemia
8. Hereditary disorder, i.e., hereditary sensory radicular neuropathy, Fabry's disease
9. Hansen's disease or neurosyphilis
10. Malabsorption syndrome
11. Multiple sclerosis
12. Traumatic injury
13. Uremia (chronic renal disease)
14. Patient on anticoagulants.

Treatment of a fungal (mycotic) infection is considered medically necessary foot care and is covered in the following circumstances:

1. A systemic condition, and
2. Clinical evidence of mycosis of the toenail, and
3. Compelling medical evidence documenting the member either:
 - (a) has a marked limitation of ambulation due to the mycosis which requires active treatment of the foot, or
 - (b) in the case of a nonambulatory member, has a condition that is likely to result in significant medical complications in the absence of such treatment.



Limitations.

1. Coverage for routine foot care must not exceed two visits per quarter or eight visits per contract year (this does not apply to Early and Periodic Screening, Diagnosis and Treatment [EPSDT] members).
2. Coverage of mycotic nail treatments will not exceed one bilateral mycotic nail treatment (up to ten nails) per 60 days (this does not apply to EPSDT members).
3. Neither general diagnoses such as arteriosclerotic heart disease, circulatory problems, vascular disease, venous insufficiency or incapacitating injuries or illnesses such as rheumatoid arthritis, CVA (stroke) or fractured hip are diagnoses under which routine foot care is covered.

Bunionectomy - Bunionectomies are covered only when the bunion is present with:

1. Overlying skin ulceration, or
2. Neuroma secondary to bunion (neuroma to be removed at same surgery and documented by pathology report).

Bunionectomies are not covered if the sole indications are pain and difficulty finding appropriate shoes.

Refer to [Chapter 800](#) for prior authorization requirements for FFS providers.



● **PRESCRIPTION MEDICATIONS/PHARMACY SERVICES**

Description. Prescription medications prescribed by a primary care provider, physician, other practitioner or a dentist and provided by a licensed pharmacy or dispensed under the direct supervision of a licensed pharmacist are covered for members, as defined in 9 A.A.C. 22, Article 2.

Amount, Duration and Scope. The following services are not covered:

1. An over-the-counter medication, in place of a covered prescription medication, is covered only if the over-the-counter medication is appropriate, equally effective, safe and less costly than the covered prescription medication.
2. Medications for the treatment of sexual or erectile dysfunction, unless used to treat a condition other than sexual or erectile dysfunction for which the medications have been approved by the Food and Drug Administration.
3. Medications personally dispensed by a physician or dentist, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed
4. Drugs included in the “Drug Efficacy Study Implementation” which are designated as ineffective, and
5. Outpatient medications are not covered under the Federal Emergency Services Program.

Limitations for prescription drug coverage include:

1. A prescription or refill in excess of a 30-day supply or a 100-unit dose is not covered unless:
 - a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is greater



- b. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is greater, and/or
 - c. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.
2. Prescription drugs for covered transplantation services will be provided in accordance with AHCCCS transplantation policies.
3. Effective January 1, 2006, with implementation of the Part D prescription drug benefit of the Medicare Prescription Drug Improvement and Modernization Act of 2003, for Medicaid members enrolled or eligible for Medicare Part D prescription drug benefits, AHCCCS continues to cover:
 - a. Medically necessary barbiturates and benzodiazepines not covered by a Part D plan, and
 - b. Non-prescription drugs not required as part of a Part D plan stepped-therapy program that are appropriate and less costly than the covered prescription drug. See Amount, Duration and Scope (#1) above.
4. Contractors may limit covered prescription drugs by developing formularies.

Return of and Credit for Unused Medications

Effective April 1, 2006, in accordance with the Deficit Reduction Act of 2005, AHCCCS and its Contractors shall require the appropriate return of and payment credit for unused prescription medications from nursing facilities (NFs) upon discontinuance of the prescription, or the transfer, discharge or death of the Medicaid member, or from other outpatient pharmacies. The pharmacy may charge a reasonable restocking fee.

Such return of unused prescription medication shall be in accordance with Federal and State laws. Arizona Administrative Code (A.A.C. R4-23-409) allows this return and redistribution under certain circumstances. Documentation must be maintained of the quantity of medications dispensed and consumed by the member and a credit issued to AHCCCS (if the member is FFS) or the member's Contractor when the unused medication is returned to the pharmacy for redistribution.



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Refer to Section 1903(i)(10) of the Social Security Act as amended by Section 6033 of the Deficit Reduction Act of 2005, the CMS State Medicaid Director Letter dated March 22, 2006, and A.A.C. R4-23-409.

Refer to [Chapter 800](#) for prior authorization requirements for FFS providers.



- **RADIOLOGY AND MEDICAL IMAGING**

Description. AHCCCS covers radiology and medical imaging services for all eligible members when prescribed by a primary care provider, other practitioner or dentist for diagnosis, prevention, treatment or assessment of a medical condition, as defined in 9 A.A.C Chapter 22, Article 2. Settings for the provision of services include hospitals, clinics, physician offices and other health care facilities.

Amount, Duration and Scope. The AHCCCS acute care program covers medically necessary radiology and imaging services.

The AHCCCS Division of FFS Management does not require prior authorization for medically necessary radiology and medical imaging services performed by FFS providers.



- **REHABILITATION THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH)**

Description. AHCCCS covers occupational, physical and speech therapy services that are ordered by a primary care provider (PCP), or attending physician for FFS members, approved by AHCCCS Division of Fee-for-Service Management (DFSM) or the Contractor, and provided by or under the direct supervision of a licensed therapist as noted in this section.

Amount, Duration and Scope. The scope, duration and frequency of each therapeutic modality must be prescribed by the PCP/attending physician as part of the rehabilitation plan. In order for the occupational, physical, and speech therapy services to be covered, the member must have the potential for improvement due to rehabilitation.

Refer to [Chapter 800](#) for prior authorization requirements for FFS providers.

Refer to [Chapter 1200](#) for additional information regarding ALTCS covered rehabilitation services.

Refer to [Chapter 1200](#) for habilitation services.

OCCUPATIONAL THERAPY

Description. Occupational therapy (OT) services are medically prescribed treatments to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost, or reduced by illness or injury. OT is intended to improve the member's ability to perform those tasks required for independent functioning.



Amount, Duration and Scope. AHCCCS covers medically necessary OT services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP/attending physician. Inpatient occupational therapy consists of evaluation and therapy.

Outpatient OT services are covered only for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, KidsCare members and ALTCS members.

OT services must be provided by a qualified occupational therapist licensed by the Arizona Board of Occupational Therapy Examiners or a certified OT assistant (under the supervision of the occupational therapist according to 4 A.A.C. 43, Article 4) licensed by the Arizona Board of Occupational Therapy Examiners. Occupational therapists who provide services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal requirements.

Therapy services may include, but are not limited to:

1. Cognitive training
2. Exercise modalities
3. Hand dexterity
4. Hydrotherapy
5. Joint protection
6. Manual exercise
7. Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device or splint
8. Perceptual motor testing and training
9. Reality orientation



10. Restoration of activities of daily living
11. Sensory reeducation, and
12. Work simplification and/or energy conservation.

PHYSICAL THERAPY

Description. Physical therapy (PT) is an AHCCCS covered treatment service to restore, maintain or improve muscle tone, joint mobility or physical function.

Amount, Duration and Scope. AHCCCS covers medically necessary physical therapy services for all members on an inpatient or outpatient basis. PT services must be rendered by a qualified physical therapist licensed by the Arizona Physical Therapy Board of Examiners or a Physical Therapy Assistant (under the supervision of the PT, according to 4 A.A.C. 24, Article 3) certified by the Arizona Physical Therapy Board of Examiners. Physical therapists who provide services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal requirements.

Outpatient physical therapy is not covered as a maintenance regimen.

Authorized treatment services include, but are not limited to:

1. The administration and interpretation of tests and measurements performed within the scope of practice of PT as an aid to the member's treatment
2. The administration, evaluation and modification of treatment methodologies and instruction, and
3. The provision of instruction or education, consultation and other advisory services.



SPEECH THERAPY

Description. Speech therapy is the medically prescribed provision of diagnostic and treatment services that include evaluation, diagnostic and treatment services that include evaluation, program recommendations for treatment and/or training in receptive and expressive language, voice, articulation, fluency, rehabilitation and medical issues dealing with swallowing.

Amount, Duration and Scope. AHCCCS covers medically necessary speech therapy services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP or attending physician for FFS members. Speech therapy provided on an outpatient basis is covered only for members receiving EPSDT services, KidsCare and ALTCS members.

ST must be provided by:

1. A qualified speech-language pathologist licensed by the Arizona Department of Health Services (ADHS), or
2. A speech-language pathologist who has a temporary license from ADHS and is completing a clinical fellowship year. He/she must be under the direct supervision of an ASHA certified speech-language pathologist. AHCCCS registration will be terminated at the end of two years if the fellowship is not completed at that time.
3. Speech-language pathologists providing services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal requirements.

Speech therapy provided on an outpatient basis is covered only for members receiving EPSDT services, KidsCare and ALTCS members.

Inpatient speech therapy consists of evaluation and therapy. Therapy services may include:

1. Articulation training
2. Auditory training



3. Cognitive training
4. Esophageal speech training
5. Fluency training
6. Language treatment
7. Lip reading
8. Non-oral language training
9. Oral-motor development, and
10. Swallowing training.



● **RESPIRATORY THERAPY**

Description. Respiratory therapy is an AHCCCS covered treatment service, prescribed by a primary care provider or attending physician for FFS members, to restore, maintain or improve respiratory functioning.

Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation care procedures, observing and monitoring signs and symptoms, general behavioral and general physical response to respiratory care, diagnostic testing and treatment, and implementing appropriate reporting and referral protocols.

Amount, Duration and Scope. AHCCCS covers medically necessary respiratory therapy services for all members on both an inpatient and outpatient basis. Services must be provided by a qualified respiratory practitioner under A.R.S. §32-3501 (respiratory therapist or respiratory therapy technician), licensed by the Arizona Board of Respiratory Care Examiners. Respiratory practitioners providing services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal requirements.

Refer to [Chapter 1200](#) for ALTCS covered respiratory therapy services.



● **SLEEP STUDIES (POLYSOMNOGRAPHY)**

Description. AHCCCS covers inpatient and outpatient sleep studies performed in the settings described below.

Amount, Duration and Scope. Sleep studies are covered services in the following settings:

1. A licensed and certified hospital facility, or
2. A non-hospital facility that meets one of the following sets of criteria:
 - a. Is licensed by the Arizona Department of Health Services (ADHS) and the facility is accredited by the American Academy of Sleep Medicine, or
 - b. Has a Medical Director who is certified by the American Board of Sleep Medicine, and has a managing sleep technician who is registered by the Board of Registered Polysomnographic Technologists, or
 - c. For sleep EEGs only, the facility must have a physician who is a Board certified neurologist. No ADHS license is required for this facility.

Limitations.

1. AHCCCS does not cover sleep studies performed in the home or in a mobile unit.
2. AHCCCS does not cover pulse oximetry alone as a sleep study.



- **TOTAL PARENTERAL NUTRITION (TPN)**

Description. TPN is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual's general condition. Nutrients are provided through an indwelling catheter.

Amount, Duration and Scope. AHCCCS follows Medicare guidelines for the provision of TPN services. TPN is covered for members over age 21 when it is medically necessary and the only method to maintain adequate weight and strength.

AHCCCS covers TPN for members receiving Early and Periodic Screening, Diagnosis and Treatment and KidsCare members when medically necessary and not necessarily the sole source of nutrition. Refer to [Chapter 400](#) for complete information.

Refer to [Chapter 800](#) for prior authorization requirements for FFS providers.



● **TRANSPORTATION**

AHCCCS covers transportation within certain limitations for all members based on member age and eligibility, as specified in the Arizona Administrative Code (A.A.C.) R9-22-211. Covered transportation services include:

1. Emergency transportation
2. Medically necessary transportation (non-emergency), and
3. Medically necessary maternal and newborn transportation.

The definitions relating to covered transportation services are as follows:

Air ambulance - Helicopter or fixed wing aircraft licensed under Arizona Department of Health Services (ADHS) as mandated by Arizona Revised Statutes to be used in the event of an emergency to transport members or to obtain services.

Ambulance - Motor vehicle licensed by ADHS pursuant to Arizona Revised Statutes especially designed or constructed, equipped and intended to be used, maintained and operated for the transportation of persons requiring ambulance services.

Description.

Emergency Transportation - Emergency ground and air ambulance services required to manage an emergency medical condition of an AHCCCS member at an emergency scene and transport to the nearest appropriate facility are covered for all members. Emergency transportation is needed due to a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:

1. Placing the member's health in serious jeopardy
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.



Emergency transportation may be initiated by an emergency response system call "9-1-1", fire, police, or other locally established system for medical emergency calls. Initiation of a designated emergency response system call by an AHCCCS member automatically dispatches emergency ambulance and EMT or Paramedic team services from the Fire Department. At the time of the call, emergency teams are required to respond; however, when they arrive on the scene, the services required at that time (based on field evaluation by the emergency team) may be determined to be:

1. Emergent
2. Nonemergent, but medically necessary, or
3. Not medically necessary.

Medically Necessary Transportation - AHCCCS covers medically necessary transportation as specified in A.A.C. R9-22-211.

Maternal and Newborn Transportation - The maternal transport program (MTP) and the newborn intensive care program (NICP) administered by the ADHS provides special training and education to designated staff in the care of maternity and newborn emergencies during transport to a perinatal center. The high risk transport team is dispatched after consultation with the MTP or NICP perinatologist or neonatologist. Only MTP or NICP Contractors may provide air transport.

Amount, Duration and Scope. Emergency transportation coverage is limited to those emergencies in which specially staffed and equipped ambulance transportation is required to safely manage the member's medical condition. Basic Life Support, Advanced Life Support, and air ambulance services are covered, depending upon the member's medical needs.



Emergency medical transportation includes the transportation of a member to a higher level of care for immediate medically necessary treatment, even after stabilization at an emergency facility. Emergency medical transportation is covered only to the nearest appropriate facility. The nearest appropriate facility for an AHCCCS fee-for-service (FFS) member is the nearest hospital medically equipped to provide definitive medical care. Contractor may establish preferred hospital arrangements, which must be communicated with emergency services providers. If the provider transports the member to the Contractor preferred hospital, the provider's claim must be honored even though that hospital may not be the nearest appropriate facility. However, the provider must not be penalized for taking the member to the nearest appropriate facility whether or not it is the Contractor preferred facility.

Acute conditions requiring emergency transportation to obtain immediate treatment include, but are not limited to the following:

1. Untreated fracture or suspected fracture of spine or long bones
2. Severe head injury or coma
3. Serious abdominal or chest injury
4. Severe hemorrhage
5. Serious complications of pregnancy
6. Shock, heart attack or suspected heart attack, stroke or unconsciousness
7. Uncontrolled seizures, and
8. Condition warranting use of restraints to safely transport to medical care.



For utilization review, the test for appropriateness of the request for emergency services is whether a prudent layperson, if in a similar situation, would have requested such services. (See [Chapter 100](#) for the definition of prudent layperson.) Determination of whether a transport is an emergency is based on the member's medical condition at the time of transport.

Refer to the section of this policy regarding medically necessary transportation furnished by an ambulance provider for information related to transportation initiated by an emergency response system call.

Air ambulance services are covered under the following conditions:

1. The point of pickup is inaccessible by ground ambulance
2. Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities; or
3. The medical condition of the member requires ambulance service and ground ambulance services will not suffice.

Air ambulance vehicles must meet ADHS licensing requirements and requirements set forth by the Federal Aviation Administration. Air ambulance companies must be licensed by the ADHS and be registered as a provider with AHCCCS.

Medically Necessary Transportation Furnished by Non-Emergency Transportation Providers:

Non-emergency medically necessary transportation is transportation, as specified in A.A.C. R9-22-211, and furnished by providers included therein, to transport the member to and from a required medical service. Such services may also be provided by emergency transportation providers after assessment by the EMT or Paramedic team that the member's condition requires medically necessary transportation.



Medically Necessary Transportation Furnished by Ambulance Providers:

Round-trip air or ground transportation services may be covered if an inpatient member goes to another facility to obtain necessary specialized diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy). Such transportation may be covered if the following requirements are met:

1. Member's condition is such that the use of any other method of transportation is contraindicated
2. Services are not available in the hospital in which the member is an inpatient
3. Member returns to the point of origin, and
4. Hospital furnishing the services is the nearest one with such facilities, or the one specified by the member's Contractor.

Transportation services to the nearest medical facility that can render appropriate services are also covered, except as provided below, if the transport was initiated through an emergency response system call and, upon examination by emergency medical personnel, the patient's condition is determined to be non-emergent but one which requires medically necessary transportation. These services are covered by AHCCCS and do not require prior authorization (PA).

Maternal and Newborn Transportation - AHCCCS covers emergency transports of newborns to a level II or level III perinatal center from a lower level of care when a need for the higher level of care is determined to be immediate and medically necessary.



Transportation to a level II or level III perinatal center for diagnostic or elective services and back transports to the same or a lower level of care are not emergencies. Such medically necessary transports are subject to PA requirements of AHCCCS Division of Fee-for-Service Management (DFSM) or the Contractor.

Transportation Services Provided for AHCCCS Native American Members Who Are Enrolled with Indian Health Service (IHS).

Emergency Transportation Services: In addition to other requirements specified in this policy, emergency transportation providers rendering services on an Indian Reservation must meet the following requirements:

1. Tribal emergency transportation providers must be certified by the Tribe and CMS as a qualified provider and registered as an AHCCCS provider
2. If non-tribal emergency transportation providers render services under a contract with a Tribe either on-reservation or to and from an off-reservation location the provider must be State licensed and certified, and registered as an AHCCCS provider, or
3. Non-tribal transportation providers not under contract with a Tribe must meet requirements specified in this policy for emergency transport providers.

As with all emergency transportation, services are covered to manage an emergency medical condition at the emergency scene and in transport to the nearest appropriate facility.



Non-Emergency Medically Necessary Transportation Services to Obtain AHCCCS Covered Medical Services

1. For AHCCCS Native American members who reside either on-reservation or off-reservation and are enrolled with IHS (Contractor ID number 999998), transportation services are covered on a FFS basis (or if available, through 100% pass-through of Federal funds) under the following conditions:
 - a. The medical service for which the transportation is needed is ordered by a licensed physician or other licensed practitioner and is a covered AHCCCS service
 - b. The request for transportation services is initiated by an IHS referral form and prior authorized through AHCCCS DFSM
 - c. The member is not able to provide, secure or pay for their own transportation, and free transportation is not available; and
 - d. The transportation is provided to and from either of the following locations:
 - (1) The nearest appropriate IHS medical facility located either on-reservation or off-reservation (facilities that are located out-of-state are subject to AHCCCS rules regarding reimbursement for out-of-state services), or
 - (2) The nearest appropriate AHCCCS registered provider located off-reservation.

For Native American members residing off-reservation who are enrolled with a Contractor, all non-emergency medically necessary transportation is coordinated, authorized and provided through the Contractor.



Non-Emergency Medically Necessary Transportation Services to Obtain AHCCCS Covered Behavioral Health Services

Members who are enrolled with IHS and live either on-reservation or off-reservation, and are receiving behavioral health services as specified in this Chapter under Policy 310, Behavioral Health Services, may receive non-emergency medically necessary on-reservation transportation services as follows:

1. Non-emergency medically necessary transportation may be provided as outlined above (#1 of the Section addressing transportation to obtain medical services) on a FFS basis (or, if available, through 100% pass-through of Federal funds) for the following members:
 - a. An IHS enrolled member, residing either on-reservation or off-reservation who is receiving behavioral health services but is not enrolled with an ADHS designated Regional Behavioral Health Authority (RBHA).
 - b. An IHS enrolled member who lives on-reservation but is a member of a tribe that is not designated as a Tribal Behavioral Health Authority (TRBHA) through an agreement with the ADHS, and who receives services at an IHS facility or through an off-reservation provider; or
2. If the member is enrolled with, and receiving behavioral health services through, a RBHA or TRBHA, non-emergency medically necessary on-reservation transportation is coordinated, authorized and provided by the RBHA or TRBHA with reimbursement through ADHS.



CHAPTER 300
MEDICAL POLICY FOR AHCCCS COVERED SERVICES

POLICY 310
COVERED SERVICES

Non-Emergency Medically Necessary Transportation Services to Obtain Arizona Long Term Care System Covered Services

All non-emergency medically necessary transportation for ALTCS FFS program members considered to be residing on an Indian reservation are covered and reimbursed through the AHCCCS Administration when authorized by the member's case manager. An IHS referral is not required for ALTCS services.

Native American ALTCS members considered to be residing off-reservation are enrolled with an ALTCS Contractor and all non-emergency medically necessary transportation is coordinated, authorized and provided through the Contractor.

Refer to [Chapter 1600](#) of this Manual for additional information regarding case management authorization requirements.

Refer to [Chapter 800](#) for complete information regarding prior authorization, and for information regarding IHS referral requirements.

Refer to the AHCCCS FFS Provider Manual or the IHS/Tribal Providers Billing Manual for billing information. These manuals are available on the AHCCCS Web site at www.ahcccs.state.az.us.



- **TRIAGE/SCREENING AND EVALUATION OF EMERGENCY MEDICAL CONDITIONS**

Description. Covered services for managed care and FFS members not in the FESP (refer to Chapter 1100 for all requirements regarding the FESP), when provided by acute care hospitals, IHS facilities and urgent care centers to determine whether or not an emergency exists, assess the severity of the member's medical condition and determine what services are necessary to alleviate or stabilize the emergent condition.

Amount, Duration, and Scope. Triage/screening services must be reasonable, cost effective and meet the criteria for severity of illness and intensity of service.

Refer to Chapter 800 for PA and utilization review requirements for FFS members.

Refer to Chapter 1100 for information and requirements regarding the FES Program.



- **COVERED TRANSPLANTS AND RELATED IMMUNOSUPPRESSANT MEDICATIONS**

Description. Organ transplant services are not mandatory covered services under Title XIX, and each State has the discretion to choose whether or not transplants will be available to members. The AHCCCS Administration, as the single State agency, has the authority under Federal law to determine which transplant procedures, if any, will be reimbursed as covered services.

When a State elects to cover transplant services, Federal law 42 USC §1396b(i) limits Federal financial participation to only those organ transplant procedures with written standards of coverage described in the State Plan. Additionally, Federal provisions authorize the Title XIX agency to impose limits on transplant services based on medical necessity and to place restrictions on the facilities and practitioners performing organ transplant procedures as long as they are consistent with accessibility to high quality care (Title 42 of the Code of Federal Regulations [42 CFR] 441.35).

AHCCCS covers medically necessary transplantation services and related immunosuppressant medications in accordance with Federal and State law and regulations.

The solid organ and tissue transplant services described in this policy, including the relevant standards of coverage, are referenced in the AHCCCS State Plan. The AHCCCS State Plan is the document approved by the Federal government which outlines the eligibility requirements and covered services for the AHCCCS program.

As with other AHCCCS-covered services, transplants must be medically necessary, cost effective, Federally reimbursable and State reimbursable. Arizona State regulations specifically address transplant services, as follows:

- Non-experimental transplants which are approved for Title XIX reimbursement are covered services (Arizona Revised Statute [A.R.S.] §36-2907).
- Services which are experimental, or which are provided primarily for the purpose of research are excluded from coverage (Arizona Administrative Code [A.A.C.] R9-22-201).



- Medically necessary is defined as those covered services “provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law to prevent disease, disability or other adverse health conditions, or their progression, or prolong life” (A.A.C. R9-22-101).
- Experimental services are defined as “services associated with treatment or diagnostic evaluation and that are not generally and widely accepted as standard of care in the practice of medicine in the United States unless:
 - The weight of the evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service, or
 - In the absence of peer-reviewed articles, for services that are rarely used, novel or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service”. (A.A.C. R9-22-101)
- Standard of care is defined as “a medical procedure or process that is accepted as treatment for a specific illness, injury or medical condition through custom, peer review or consensus by the professional medical community” (A.A.C. R9-22-101).

In developing this policy, the AHCCCS Administration has consulted with transplant experts to develop criteria for transplant coverage consistent with the current body of medical literature, including United Network for Organ Sharing (UNOS) clinical standards for transplant procedures as well as peer-reviewed articles in medical journals published in the United States.

It is the AHCCCS Administration’s position that the criteria delineated in this policy represent current accepted transplant medical knowledge and the current standard of care in the professional transplant community for determining when transplants are medically necessary and non-experimental. Emerging technologies and advances in medical treatments will likely alter the standards set forth in this policy. In light of the evolving body of transplant knowledge, it is expected that each AHCCCS Contractor will consult with up-to-date authoritative medical sources to determine whether a particular transplant is medically necessary and non-experimental, and provide the medical justification for the decision that is made.



The transplant policy sets forth criteria, including indications and contraindications, for determining whether transplant services are medically necessary and non-experimental. Contraindications are conditions which may significantly adversely impact the outcome of the transplant, however, they are not regarded as an absolute bar to transplantation. Contraindications must be evaluated along with all other relevant factors to determine whether the transplant service is medically necessary and non-experimental in the particular case.

Both general and organ/tissue specific contraindications are listed in this policy. General contraindications are found under the heading “General Contraindications”, and organ/tissue specific contraindications are identified in Attachment A. This policy also describes some of the general medical conditions which must be considered to determine the appropriateness of the transplant. The general medical conditions that must be evaluated in establishing the medical necessity and the non-experimental nature of the transplant service are found under the heading “General Medical Conditions that Must be Considered”.

Transplant services are covered only when performed in specific settings:

- Solid organ transplantation services must be provided in a CMS certified transplant center that is contracted with AHCCCS and that is also a UNOS approved transplant center, unless otherwise approved by the member’s Contractor, and/or the AHCCCS Chief Medical Officer (CMO), Medical Director or designee.
- Stem cell and bone marrow transplantation services must be provided in a facility that has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation as a stem cell and bone marrow transplant center and is contracted with AHCCCS, unless otherwise approved by the member’s Contractor, and/or the AHCCCS Chief Medical Officer (CMO), Medical Director or designee.

Transplantation related services and immunosuppressant drugs are not covered services for individuals in the FES program, pursuant to 42 USC 1396b(v)(3) and A.A.C. R9-22-206. Persons who qualify for transplant services, but who are later determined ineligible under A.R.S. 36-2907.10 due to excess income may qualify for extended eligibility (refer to Attachment B). For information about transplants and reinsurance, refer to the AHCCCS Contract.



- A. The first step in the assessment for transplant coverage is the initial evaluation by the member's PCP and/or the specialist treating the condition necessitating the transplant. In determining whether the member is appropriate for referral for transplant services, the PCP/specialist must determine that all of the following conditions are satisfied:
1. The member will be able to attain an increased quality of life and chance for long-term survival as a result of the transplant
 2. There are no significant impairments or conditions that would negatively impact the transplant surgery, supportive medical services, or inpatient and outpatient post-transplantation management of the member
 3. There are strong clinical indications that the member can survive the transplantation procedure and related medical therapy (e.g., chemotherapy, immunosuppressive therapy)
 4. There is sufficient social support to ensure the member's compliance with treatment recommendations such as, but not limited to, immunosuppressive therapy, other medication regimens and pre- and post-transplantation physician visits, and
 5. The member's condition has failed to improve with other conventional medical/surgical therapies. This information must be documented and submitted to the Contractor at the time of request for evaluation.
- B. The following solid organ and tissue transplants are AHCCCS covered services when medically necessary and non-experimental. For detailed criteria regarding specific transplants, refer to Attachment A.
1. Heart
 2. Heart/Lung
 3. Lung – single and double
 4. Liver



5. Kidney (cadaveric and live donor)
6. Simultaneous Pancreas/Kidney and Pancreas after Kidney
7. Intestinal transplantation (pediatric members only)
 - a. Small Bowel
 - b. Liver/Small Bowel

NOTE: Live donor transplants may be considered on a case-by-case basis for solid organs other than kidney when medically appropriate.

8. Bone Marrow or Stem Cell
 - a. Allogeneic (related and unrelated)
 - b. Autologous
 - c. Related and unrelated cord blood stem cell (for specific diagnoses in children and adults)
9. Donor Lymphocyte Infusion (DLI)
10. Tandem bone marrow transplants or double organ transplantation consisting of multiple of the above covered organs is covered.

C. Ventricular Assist Device (VAD) is an AHCCCS covered service when used as a bridge to transplantation and other specific criteria are met (refer to Attachment A).

D. Bone grafts and corneal transplants are AHCCCS covered services.



Amount, Duration and Scope. Coverage of transplantation services includes the following components of service, as required by the specific type of transplantation:

A. For the transplant recipient and donor:

1. Pre-transplant evaluation (inpatient or outpatient), which includes, but is not limited to, the following:
 - a. Physical examination
 - b. Psychological and social service evaluations
 - c. Laboratory studies
 - d. Diagnostic imaging, and
 - e. Biopsies
2. Medically necessary post-transplant care (inpatient and outpatient), which may include, but is not limited to, the following:
 - a. Laboratory studies
 - b. Diagnostic imaging
 - c. Biopsies, and
 - d. Treatment of complications

B. Additional covered services for the transplant recipient only:

1. Nutritional assessment



2. Dental evaluation and treatment for oral infection. (For adults, this service is limited to diagnosis and treatment for the elimination of oral infection, and will commence only after the member has been established as an otherwise appropriate candidate.) Other dental services, including, but not limited to, restorative and cosmetic dentistry, will not be covered.
 3. Pre-transplant inpatient and outpatient donor search
 4. Room and board for the transplant recipient and, if needed, one adult caregiver during the time it is necessary for the member to remain in close proximity to the transplant center
 5. Hospitalization from the date of admission for the transplant to discharge
 6. Transportation for the transplant recipient and, if needed, one adult caregiver to and from medical treatment during the time it is necessary for the member to remain in close proximity to the transplant center
 7. All related medications, including immunosuppressants. Note: AHCCCS is the secondary payer of immunosuppressant medications if the member is also a Medicare beneficiary and is eligible to receive the immunosuppressant medications under either Medicare Part B or Part D.
 8. Post-transplant discharge evaluations
- C. Additional covered services for the donor:
1. Inpatient or outpatient donor organ, tissue or cell procurement, processing and storage
 2. Preparation and transplantation services from date of admission through day of transplant, and
 3. Post-transplant follow-up visit.



GENERAL CONTRAINDICATIONS

General contraindications to solid organ and tissue transplantation include, but are not limited to:

1. History of non-compliance or psychiatric condition(s) such that there is an inability to comply with an immunosuppression protocol
2. HIV positive status and viral load – members whose HIV status makes them ineligible for AHCCCS coverage of transplantation have the potential to enroll in one of the National Institute of Health's approved clinical trials. These transplants are subject to the policy described in the section of this policy entitled "Medically Necessary Services for Members who Receive Transplants that are Not Covered by AHCCCS".
3. Active malignancy (other than hepatocellular carcinoma for liver transplants) or prior metastatic disease. This is a contraindication to solid organ transplant, not stem cell transplant.
4. The failure of more than two organs. This does not include instances where the failure of one organ is secondary to the failure of another organ.
5. Presence of active infection other than that which has caused the underlying organ failure.
6. Active substance abuse or history of substance abuse in the last six months. (If there is an urgent need, evaluation only may be allowed on a case-by-case basis.)

GENERAL MEDICAL CONDITIONS WHICH MUST BE CONSIDERED

The general medical conditions that must be evaluated prior to transplant to determine whether a particular transplant is medically necessary and non-experimental include, but are not limited to:

1. Morbid obesity (body mass index [BMI] of $> 39 \text{ kg/m}^2$). This consideration does not pertain to stem cell and bone marrow transplantation.



2. For members with a history of substance abuse, six months of current, ongoing attendance in an approved substance abuse program, plus a patient-signed contract, sponsor and paper documentation of attendance in the program are required prior to determination for transplant listing. For members with a remote history of substance abuse (greater than three years prior), attendance in an approved substance abuse program may be waived. All members with a history of substance abuse must have three consecutive negative random screens reported by the PCP and/or specialist prior to the referral to the transplant facility for evaluation. In addition, the member will be monitored with random and repeated alcohol and/or drug screening during the assessment process up to the time of the transplant.
3. Comorbid conditions (e.g., systemic lupus erythematosus, cystic fibrosis, sarcoidosis) are relative contraindications, based on the severity of the disease.

Out-of-Network Coverage. AHCCCS provides out-of-network coverage for solid organ or stem cell and bone marrow transplants for those members who have current medical requirements that cannot be met by an appropriate in-network transplant center. These medical requirements must be manifested as requiring either a specific level of technical expertise or program coverage that is not currently provided by AHCCCS contracted facilities. A request for out-of-network coverage will not be approved if the member has already received a medical denial from an approved transplant center. Quality, outcome data and cost containment standards will all be considered in the final determination for use of out-of-network transplant centers.

When a member completes an AHCCCS approved transplantation at an out-of-network facility, the necessary follow-up services will be covered through an AHCCCS contracted in-network facility, if one is available. These services include, but are not limited to, travel, lodging, meals, medical testing and post-operative evaluation and apply to any transplant performed under AHCCCS coverage, another third-party payer or through self-pay.



Multiple Site Listing for Solid Organ/Stem Cell and Bone Marrow Transplantation.

If a member seeks to be evaluated for solid organ, stem cell or bone marrow transplantation, and is "listed" with more than the primary approved transplant center, AHCCCS will not pay for any of the other center's evaluation services or any travel, lodging or meals.

In the event that a member becomes listed by a facility other than the primary approved transplant center, AHCCCS will not provide coverage for any costs over and above the state-contracted rate for the specific transplant procedure.

In addition, facility reimbursement will be available only to FACT accredited or CMS certified and UNOS approved transplant centers unless otherwise approved by the member's Contractor, and/or the AHCCCS CMO, Medical Director or designee, and will be limited to the immediate hospitalization for the transplantation surgery and the inpatient post-operative care.

If a member chooses to make their own arrangements for travel, lodging and/or meals, then the member must notify their Contractor (or AHCCCS if they are a fee-for-service [FFS] member), of the arrangements they have made, and for securing and sending appropriate medical records to the appropriate transplant case manager. If the member is receiving services on an FFS basis through AHCCCS Administration, appropriate medical records must be sent to the transplant case manager in the AHCCCS Division of Health Care Management.

Medically Necessary Services for Members who Receive Transplants that are Not Covered by AHCCCS. If a member receives a transplant that is not covered by AHCCCS, medically necessary, non-experimental services commence following discharge from the acute care hospitalization for the transplant.

A. Services include, but are not limited to:

1. Transitional living arrangements appropriately prescribed for post-transplant patients
2. Essential laboratory and radiology procedures



3. Medically necessary post-transplant therapies
 4. Immunosuppressant medications, and
 5. Medically necessary transportation
- B. Covered services do not include:
1. Evaluations and treatments to prepare for transplant candidacy
 2. The actual transplant procedure and accompanying hospitalization, or
 3. Organ or tissue procurement.

AHCCCS reimbursement of the Contractor for medically necessary services following non-covered organ transplantation is in accordance with the regular reinsurance policy. Reimbursement in accordance with catastrophic reinsurance policy is reserved for AHCCCS-covered transplantation.

Transplantation Management. The AHCCCS Administration has entered into a contract with a transplantation management entity (Consultant) to review developments, outcomes and respective changes in technology, and assist in the development and revision of this policy. The Consultant will be available, as necessary, to advise on cases that require expert opinion regarding transplantation services.

AHCCCS, in partnership with the Consultant, will provide medical expertise for specific diagnoses and medical conditions that are covered for transplantation.

Consultation may include, but is not limited to:

1. Telephone access to the Consultant Medical Director. Access will be arranged by the AHCCCS Chief Medical Officer or designee.
2. Regular updates on changes in experimental status of selected transplants and advances in technology and devices



3. Analysis of transplantation and related technology developments with enough information, including cost projections, to assist AHCCCS in revising this policy and Attachment A as necessary, and
4. Assistance in recommendation of approved/appropriate transplant facilities, as necessary, for out-of-network coverage.

References.

1. Attachment A of this Policy for criteria for specific solid organ and tissue transplants.
2. Attachment B of this Policy for extended eligibility process/procedure
3. [Chapter 500](#) for information regarding care coordination for transplant candidates who experience an interruption of eligibility or enrollment
4. [Chapter 800](#) for fee-for-service prior authorization requirements for providers
5. AHCCCS Division of Health Care Management, Reinsurance Claims Processing Manual, for information regarding Contractor applications for transplantation reinsurance, and
6. The AHCCCS Contracts for further information regarding transplants and reinsurance.